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"Water can" penis caused by tuberculosis

Tuberculosis of the penis is a very rare condition, clinically manifesting as primary or secondary tuberculosis or tuberculide.¹ Penile involvement secondary to urethral tuberculosis is rare and its presentation with periurethral fistulas leading to "water can" penis is unknown. We report this rather intriguing condition in a patient.

A 40 year old male agricultural labourer presented with a 1 year history of purulent discharge per urethra with multiple discharging sinuses on the tip of the penis. The patient was asymptomatic about a year ago, when he developed multiple nodules on the glans penis that ulcerated to discharge purulent material. These nodules became persistent sinuses and discharged pus. Within a few weeks, he started passing urine through these sinuses in the glans penis. He also experienced difficulty in micturition but it was not associated with pain or strangury. The patient had no systemic complaints. He was married with two children and had no history of extramarital contact or genital ulcers.

On physical examination, the penis shape was like a saxophone. The prepuce and glans penis were oedematous and indurated. The glans penis had multiple sinuses around the urethral meatus (fig 1). On squeezing the penis, pus was expressed from the meatus and the sinuses. The glans penis also showed areas of depigmentation (vitiligo). The distal part of the shaft of the penis showed induration involving corpora cavernosa whereas the proximal part was devoid of any lesion. The testes, bilateral epididymis, and scrotum were normal. The vas deferens was normal on



Figure 2 Forearm showing positive Mantoux reaction.

palpation. The prostate was normal on rectal examination.

The routine haemogram revealed an elevated erythrocyte sedimentation rate of 100 mm in the first hour. His liver and renal functions were normal. The discharge smear stained with Gram stain and Zeihl-Neelsen stain. The Gram stained smear revealed numerous pus cells and acid fast stain showed abundant acid fast bacilli. Culture for *Mycobacterium tuberculosis* grew contaminants. A roentgenogram of the chest and penis was unremarkable. An intravenous pyelogram was normal. Voiding cystourethrography revealed glandular urethral stricture with urethrocutaneous fistulas. Ultrasonography of abdomen and prostate was normal. Mantoux skin test was strongly positive (30×30 mm) (fig 2). His venereal disease research laboratory test (VDRL) and HIV serology was non-reactive.

Based on these clinical features, positive Mantoux test and acid fast bacilli in the urethral smear, the diagnosis of urethral tuberculosis with urethrocutaneous fistula was made. The patient was started on anti-tuberculous treatment comprising isoniazid 300 mg, rifampicin 600 mg, pyrazinamide 1500 mg, and ethambutol 800 mg per day. The patient showed marked improvement after 4 weeks of treatment. The sinuses closed and discharge ceased. Patient was referred to urology for management of stricture, which was planned after the anti-tuberculous treatment. The patient tolerated antituberculous treatment and completed 9 months of treatment with remarkable recovery in the swelling of the penis.

Genital involvement occurs in 50% of male patients with urogenital tuberculosis. Penile tuberculosis is rare with less than 1% of patients having penile involvement.² Tuberculosis of the penis usually presents as ulcers, tubercular cavernositis, or nodules. In most cases, the lesion appears as a superficial, solitary, painless ulcer on the glans penis. It can be clinically indistinguishable from malignant disease.³ Rarely, lesions may persist as solid nodule or cavernositis with ulceration.^{4,5} Papulonecrotic tuberculide may also present as an ulcer on the penis.¹ Penile

involvement may occur secondary to co-existing urinary tract tuberculosis. The transmission occurs secondary to bacilluria in these patients. Infection of the penis may occur by direct contact at the time of intercourse with a partner having urogenital tuberculosis.²

Tuberculosis of male urethra is an uncommon condition and presents as urethral strictures, periurethral abscesses, or fistula formation. Fistulas can occur in the perineum leading on to "water can" perineum.⁶ Similar occurrence of fistulas in penis can aptly be designated as "water can" penis. In our case, penile involvement occurred secondary to urethral tuberculosis. Such involvement of the penis by tuberculosis is unique and not reported in the literature. "Water can perineum" is also known to occur with gonorrhoea but our patient had a negative urethral smear for Gram negative diplococci and had features suggestive of urethral tuberculosis. Further, the strictures, fistulas, and lymphoedema had led to "saxophone" deformity of the penis. Such deformity is well known with lymphogranuloma venereum, but is unknown in tuberculosis.

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South Asians with HIV in London: is it time to rethink sexual health service delivery to meet the needs of heterosexual ethnic minorities?

Recent conservative estimates suggest that at the end of 2002, 4.8 million people were living with HIV/AIDS in south Asia including 4.58 million in India.¹ In the United Kingdom there are estimated to be 1.5 million people of south Asian ethnicity. While the National Strategy for Sexual Health aims to improve health care in those who have HIV through earlier diagnosis,² studies have shown that that other ethnic minority groups present with advanced disease and not through routine genitourinary medicine (GUM) screening.^{3,4} We studied the case notes of all adults self defining as of Indian, Pakistani, Bangladeshi, or Sri Lankan ethnicity diagnosed HIV positive from



Figure 1 Saxophone penis with multiple sinus openings over the glans penis.